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ABSTRACT

The literature review of continuing education in nursing surveys 123 journal articles, books, conference reports and proceedings, and other publications published between 1960 and 1970. The review is divided into the following sections: prologue, which surveys the health professions, and new directions and limitations within them; the profession and continuing education, which examines nurse composition and distribution and concern for continuing education; participation in continuing education, which discusses characteristics of participants and their reasons for participation or not; program organization and administration, which examines sponsors of programs, program administration, some sample programs, and recurring issues and trends; summary, which synthesizes the literature on nursing; and epilogue, which summarizes participation, programs, and research for the four health professions of nursing, medicine, pharmacy, and dentistry; and references. (JR)

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CONTINUING EDUCATION IN NURSING

A Review of North American Literature 1960-1970

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W.K. KELLOGG PROJECT REPORT # 4

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No. 2 Proceedings of a Conference on Inter Professional Continuing Education in the Health Sciences.

No. 3 Continuing Education in Medicine: A Review of North American Literature 1960 - 1970.

No. 4 Continuing Education in Nursing: A Review of North American Literature 1960 - 1970.

No. 5 Continuing Education in Dentistry: A Review of North American Literature 1960 - 1970.

No. 6 Continuing Education in Pharmacy: A Review of North American Literature 1960 - 1970.

INTRODUCTION

An important developmental task for an emerging field is that of consolidating past experiences to provide guidelines for the growth that is to follow. The decade of the '60's was a landmark era in the development of continuing education in nursing as it was also for other health professions. During this period the importance of continuing education was recognized and accepted more fully by leaders in the profession. Earlier practitioners and scholars in nursing set down many useful guidelines for the further development of continuing education in nursing and some empirical research was initiated during the decade.

The Authors of this review are commended for their careful search of the literature to insure that early leaders are properly credited for their contributions. Through their critical analysis and integration of published materials about continuing education in nursing they have provided an excellent map of the achievements in the field during the past decade. Out of this view has come a better understanding of the task that confronts continuing nurse educators of the present and future. This task is both immense and challenging. It should move Continuing Nursing Education from a position of marginality into the mainstream of Nursing Education.

This publication will serve as a handbook for the practitioner and for the research scholar in the field of continuing nursing education. From this we can measure progress through a similar review at the end of the present decade.

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Continuing Education in Nursing.

University of British Columbia
November, 1972.

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The authors are grateful to the many people who have assisted in the preparation of this review. Special thanks are due to Miss Jane Corcoran for preparing the manuscript for the press.

June Nakamoto
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Vancouver, B.C.
July, 1972.

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CHAPTER 1

PROLOGUE

One of the most conspicuous and indeed alarming features of modern life is the rapid growth, proliferation, and diffusion of knowledge in every area of human endeavour. This is having an impact upon individuals and social institutions more profound than one can easily conceive or readily accept. It is producing changes that erode cherished myths about education which destroys personal and institutional security.

Individuals can no longer enjoy the security that is based on levels of educational attainment for new knowledge quickly makes past learning obsolete. The higher the original level of educational achievement, the more quickly obsolescence occurs; consequently, the several professions are more significantly threatened by change. At the same time, the accepted roles of social institutions are undermined. As new knowledge permeates all segments of society it alters the function and purpose of each institution in its relationship to others and to society in general. The firmly entrenched institutions are most threatened since their security is based on traditional responses to problems which new knowledge has made obsolete.

To survive in a changing world, both individuals and institutions must continue to learn. Such learning does occur but as DeCrow (6) has noted, much of it

> ...is happening unintentionally, largely unobserved, and without the slightest conscious direction. It is happening of necessity, almost as a reflex motion of a society grappling with social forces which are remoulding a nation to confront the challenges of a rapidly changing world.

But learning cannot be left to chance and without "... the slightest conscious direction." There is too much to be learned, too little time to learn it in, and too many distractions in the work-a-day world to ensure that the learning required will be achieved. In the past, such learning to keep abreast of new knowledge was thought to be an individual responsibility but few individuals accepted that responsibility so that the majority became obsolete and dysfunctional in a changing society. Consequently, it is becoming increasingly obvious that continuous learning is a responsibility that must be shared by both individuals and by society.

Some individuals and institutions have accepted this responsibility for continuing education more readily than have others and over a longer period of time. Adult Education has been an integral part of society for centuries but for the most part it has existed outside the institutional structure as an activity of individuals concerned about their own personal need for systematic learning opportunities or with a philanthropic concern for the needs of others. It is only within the past century that educational institutions have begun to accept a responsibility for continuing education but not yet to the extent that it helps shape the self-image of the institutional role and function in society. At the moment, adult education is still largely a marginal activity.

The several health professions are just now becoming aware of their role in and responsibility for the continuing education of their members. For the most part this has been forced on them and accepted with some reluctance through fear of losing control of their own destiny to other forces in society. In implementing this newer responsibility the health professions have not modified their traditional perceptions of learning

and education in light of new scientific knowledge about adult education so that their continuing education programs do not usually achieve the learning and changes in behavior necessary for improved patient care.

THE HEALTH PROFESSIONS

The scientific and socio-economic factors accentuating the need for continuing education in the health professions has been well documented in many health manpower reports (22, 21, 24, 19) and by numerous leaders in the health field (5, 15, 13, 3, 27). Research is producing new knowledge in the health field at an unrelenting pace. Science has made massive strides in the understanding, cure, and prevention of ill health so that life expectancy has been increased two-fold. At the same time, it has become increasingly apparent that new and better means must be found to hasten the application of new knowledge for the improvement of health care.

An increasingly informed public aware of new discoveries and demanding them has accentuated the need to hasten the spread and use of knowledge. Higher education and income levels, as well as expanded coverage by health insurance schemes is shifting the role of the consumer as 'patient' to that of 'buyer' thereby strengthening his position to demand more and better health services. A growing egalitarianism now views health care as a basic human right which should be readily available to all with equal quality.

In response to the changing nature of public expectations, universities and professional associations, joined by health service agencies and institutions, are attempting to prevent obsolescence by increasing their involvement in continuing education. Although some interest and activity in continuous learning has long been the concern of

some individual members of the health professions, it is only within the past decade that professional groups have concentrated their attention upon the provision of systematic educational opportunities for all in the professions.

In spite of this rapidly growing interest and concern it is everywhere apparent that continuing education is a responsibility not yet discharged satisfactorily or adequately at all levels (10, 12, 14, 19, 20). Moreover, as noted by Houle (11):

> ... even more disconcerting is the expression of a growing public hostility toward the several professions because of the alleged incompetence or self-satisfaction of their individual members, faults which better continuing professional education might have helped to prevent.

Although the case is not clear, the view is expressed widely that continuing education in the health sciences suffers from a lack of clear purpose, an absence of professional interest, and incompetence in the provision and conduct of educational activities. There is also widespread the impression that programs are ad hoc or piecemeal instead of continuing, and designed along the traditional lines of youth education rather than taking into account that the potential participants are adults.

Whatever the crux of the problem, the general consensus is that present programs have many shortcomings and that newer and more effective approaches must be found. Recent government reports recommending that "... professional associations explore the means whereby continuing education could be made a condition for practice ..." have added a new sense of urgency to the task (19, 21).

NEW DIRECTIONS

At present, programs for continuing education in the health professions are constructed largely on the model of academic pre-professional education which is controlled exclusively by subject matter and conducted primarily to disseminate information. This approach to learning stems from the prior educational experience of those planning the program as they generally lack sufficient knowledge about adult learning and instruction to do otherwise. Furthermore, as a result of their prior experience in pre-professional education, those for whom progams are planned resist educational activities that violate traditional conceptions regardless of their efficacy for learning. Since the traditional approach to education is not fulfilling the need, continuing education for health professionals must seek new directions.

In order to design new directions, it is necessary to examine existing activities in continuing education. This review, therefore, is a summary and analysis of the literature on continuing education in the health professions from 1960 to 1970 in order to provide a basis to seek new directions. By studying existing patterns of education for the professions it will be possible to avoid earlier mistakes and profit from prior experiences in designing functional educational programs.

CLARIFICATION OF TERMS

The term continuing education has been defined in various ways in the health sciences. Some definitions are broad and encompass all education following the completion of pre-professional programs in undergraduate study (1, 16). In other cases, the term is defined in a very restrictive sense to apply only to short refresher-type courses (9, 12).

Still others use the term as a synonym of adult education to include all learning activities which contribute to personal growth and development. In this sense, as noted by Cameron (2) "... the proportions of the task are formidable indeed".

As used in this review, continuing education includes any educational activity for health professionals "... through which opportunities for systematic learning are provided" (18). Thus, any planned learning experience is included in this term and these range from formal courses through conferences, conventions, institutes or workshops, to clinical traineeship so long as they are conducted for practising professionals and are systematic learning activities.

Instructional devices such as recordings, films, television, radio or programmed instruction are also included in this review where appropriate. For the most part such devices are used principally as information sources, to aid in self-instruction, or as ways of extending the range of an instructor to include widely dispersed participants.

The terms course and program are used interchangeably in this review and refer to those learning activities which are designed to achieve specific instructional objectives within a specified period of time. Thus, a program may consist of a single instructional event such as an evening meeting or a one day institute, or it may be a sequential series of events occurring regularly over a period of time (25).

The term method and technique are generally used interchangeably in the literature without specification. A method is a way of organizing the participants for the purpose of conducting a learning activity and may include correspondence study, classes, workshops, ward rounds, or clinical traineeships. A technique, on the other hand, identifies the

behaviours that occur in the instructional situation which are intended to help the participant learn and includes such things as the lecture, panel, symposium, discussion, demonstration and similar actions.

Learning is used here to identify the process through which an individual acquires a new capability that is a more or less permanent change in behaviour resulting from experience such as acquiring new information, a new skill, or an attitude.

The term instruction is used to identify the action of an agent who designs and manages a learning activity in order to achieve greater success in learning.

LIMITATIONS

This review is primarily concerned with basic program development for continuing education in the health professions. Most of the literature reviewed has been descriptive in nature covering a single program or a survey of program activities. There has been very little done in the way of substantive research and such as is available often fails to satisfy the rigorous canons of social science so that there is little validity or reliability in the data or conclusions presented. Perhaps if it accomplishes no other useful purpose, this review may spur the several professions to engage in research that is functional in answering the many problems identified in the literature.

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CHAPTER II

THE PROFESSION AND CONTINUING EDUCATION

For those familiar with the nursing profession, it would seem superfluous to reiterate the many well known and well documented problems in nursing. Nevertheless, in order to understand both the limitations on and the needs in continuing education, it is necessary to re-examine briefly some of the problems as well as the trends in contemporary nursing.

NURSE COMPOSITION AND DISTRIBUTION

Nurses comprise the largest single group of health professionals, and even ignoring the vast number of practical nurses, orderlies, and other auxiliary nursing personnel, the nurse-patient ratios in Canada and the United States are among the highest in the world, 1:164 (76) and 1:302 (69) respectively. Moreover, for the past several years, employed registered nurses have been increasing at a rate of approximately 3 percent per year in the United States (31) and by 7 to 8 percent per year in Canada (30). These figures are less impressive when one considers that roughly one quarter of the nurses are employed part-time and that the attrition rate is high in nursing (57). Since nursing is largely a women's profession of whom well over one-half are married (76), it is expected that these trends will continue in future.

At the same time, a number of studies (101) (122) (57) disclose that a significant percentage of inactive nurses would be willing to re-enter the work force, provided refresher courses were made available. They also suggest that the majority of inactive nurses are diploma graduates and most are seeking part-time employment. As pointed out in

the recent report of the National Commission on Nursing and Nursing Education (69), while re-activation of this group may well satisfy certain manpower needs, it does not necessarily meet the need for nurses with advanced educational preparation, nor does it necessarily guarantee a stable work force.

In 1968, the majority of Canada's registered nurses had no academic degree, 5 percent had a baccalaureate, and less than 1 percent had a higher degree (30). Comparably, in 1966, only 10.6 percent of the registered nurses in the United States had baccalaureates, and 2.5 percent a higher degree (5). On the other hand, the general consensus is that 25 to 33 percent of the present positions in nursing require at least a baccalaureate (76). These data lend support to the conclusion that "the production of a sufficient number of nurses may be less of a problem than the production of enough nurses with higher degrees for those positions where it is felt that such preparation is essential" (57).

Trends in Composition and Distribution:

Of the registered nurses at work the majority are employed by institutions and agencies, particularly by hospitals. Indeed, as shown in Table I, the most significant trend over the past forty years has been the decline of independent practice. In spite of the increasing emphasis on community health care, in 1968 only 8 percent of employed nurses in Canada were engaged in public health or occupational health nursing, as compared to 15 percent in 1930. Recent employment statistics on nurse manpower in the United States suggest a similar distribution in that country (6).

The average annual turnover rate for registered nurses working general

TABLE I

PERCENTAGE DISTRIBUTION OF EMPLOYED NURSES BY FIELD OF EMPLOYMENT IN CANADA 1930, 1960, 1968.

Field of Nursing	1930	1960	1968
Private Duty	60	9	4
Hospitals/Nursing Schools	25	59	83
Public/Occupational Health	15	7	8
Other or Unspecified: Includes - Physician or Dentist Office: Other specified field		25	5
TOTAL	100	100	100

SOURCES: COUNTDOWN: 1969: Canadian National Statistics: Canadian Nurses' Association, Ottawa, p. 13

Kohn, R., Emerging Patterns of Health Care, Ottawa: Royal Commission on Health Services: Queen's Printer, 1966, p. 24.

duty in hospitals in 60 percent in Canada (75), and 70 percent in the United States (69). Using the oft quoted estimate provided by Taub and Melbin of "$500 to replace one nurse" (108), the economic implications of these turnover rates is obvious. Equally significant, however, is the loss in terms of nurse effectiveness, not only to the new staff nurse but also to all those involved in her orientation. As one in-service co-ordinator writes, "Inservice education is not a luxury or something nice to have in a hospital, it is a necessity. Because of a rapid turnover of personnel our audience is a parade" (113).

Because nursing is a profession composed largely of female workers this may account for the high turnover but according to Murray (75), the turnover rate in nursing is anywhere from 20 to 30 percent higher than for other predominately female occupations. In his study, Murray attempted to identify those variables accounting for the rapid turnover of general staff nurses. He found that with the exception of younger nurses who tended to be more mobile, no clear pattern emerged. On the average, part-time nurses were no more nor less stable than full time staff. Nor did size of hospital or size of community necessarily correlate with job mobility. He did conclude that "nursing turnover is not all a case of being 'pulled'away from a job; at least some of it may be due to being 'pushed' as a result of dissatisfaction with a particular situation." He recommended - as have many others (89) (15) (69) - that "small work groups be created to foster a feeling of autonomy and belonging, and that provision be made for inservice education which would increase professional development and make staff more capable of contributing to the decision making process" (75)

Changing Patterns of Practice:

As new patterns of medical care evolve, the role of the nurse is

changing. Nursing in hospital has become increasingly managerial, specialized, and technical, and many patient care procedures formerly carried out by physicians are now performed by nurses (62). Whether or not the nurse should meet these ever increasing demands is debatable and many attempts have been made to clarify the 'unique'functions of the nurse (95) but there still remains considerable confusion on the part of nurses, physicians, and other members of the health team as to what is the role of the nurse (109), (89), (75).

Adding to the problem of role has been that of qualifications. There has been a struggle within the nursing profession over the adequacy of the two, three, or four year pre-professional educational program. While much has been written comparing graduates from the different programs, there is little concrete data to assess differences. A recent analysis of test results by the National Commission on Nursing and Nursing Education (69), disclosed a considerable overlap in the scores achieved by graduates of all three types of programs, and with at least as much variation within each. On this issue, the Commission simply concludes:

> While it can be expected that greater differences will emerge in areas like clinical performance ... it seems likely that differences within the programs will be at least as great as differences between them, and any health care facility that employs nurses must take these variations into account in its orientation and induction procedures.

In the practice setting any consideration of individual differences appears to be the exception rather than the rule. One recent survey of eighty directors of nursing service disclosed that the "standard measuring stick" for all graduates was their ability to 'cope' and function within the traditional hierarchial structure of nursing service which in effect means rating the nurse according to the amount of administration and other task oriented experiences she has had (35).

Harrington and Theis (50) found that under such circumstances, many baccalaureate graduates suffered role deprivation. On the other hand, Price (89) noted that at all levels and regardless of educational preparation, there was "an unintentional commitment on the part of the nurses to the perpetuation of the system". Thus she concludes, "Both preservice education and hospital organization must be changed to improve the situation".

While the present organization of nursing services is an anachronism, the fundamental difficulty in assessing these problems is the lack of research into nursing practice. There is "little objective evidence available upon which to base judgements as to what is the proper scope of practice, what class and types of practitioners are needed, and what kinds and amounts of education each requires" (93).

In recent years university graduate programs in nursing have focussed on the preparation of expert nurse practitioners or clinical specialists who can help define nursing practice in the clinical areas and conduct research into patient care. Although many consider this one of the most promising trends in nursing, it is now being questioned as to whether a "sufficient number of clinical specialists can be produced to make a significant impact on the overall system" (78).

In the meantime, as the need for health services accelerates, physician directed programs designed to produce nurse clinicians in the acute and ambulatory care settings have been increasing, and while both physicians and nurses appear to agree that as health care needs change roles must change, so that the role of the nurse is expanded, there is little agreement about the educational preparation required. A recent study in Ontario (97) disclosed that while nursing educators believed that the expert nurse clinician should be prepared at the graduate university

level, the Ontario Medical Association maintained that such a person need be only a diploma graduate, with several years of on-the-job training resulting in clinical competence in one area of nursing. A recent interprofessional survey in the United States disclosed similar findings (98).

Despite these opposing viewpoints, both groups are much more willing to compromise on behalf of optimum patient care, and this reciprocity of roles is evident (65), (8). While professional isolationisms will not soon be resolved, changes in the reciprocal roles of physicians and nurses is a significant trend that has important implications for continuing education in nursing.

CONCERN FOR CONTINUING EDUCATION

The American Nurses' Association (7) includes three types of educational activities under the term continuing education for nurses*:

1. Formal academic study in programs leading to a baccalaureate or higher degree;

2. Short term courses or programs offered by institutions of higher learning but not necessarily directed toward a degree (these are generally referred to as "continuing education courses"), and:

3. Independent or informal study carried on by the practitioner herself utilizing the learning opportunities available to her through her profession or her employing agency.

This review is concerned with the latter two categories of continuing education, but more particularly with those non-credit courses sponsored by institutions of higher learning, and inservice education provided by employing agencies.

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*The term "nurse" as used in this report refers to those registered nurses graduated from hospital schools, junior colleges, and university schools of nursing.

Of the two types of programs, inservice education is the oldest, and probably still the most prevalent form of continuing education in nursing. Pfefferkorn's historical review (88) published in 1928 provides evidence that as early as 1905 postgraduate nursing courses were being offered in a variety of medical specialties. She reports that these programs were not well developed and that many were being given merely to increase the work force of the hospital. She further notes that educational opportunities for the general staff nurse were almost non-existent.

Straub (107) reviewed the nursing literature between 1928 and 1960 but found few articles related to the inservice education of nurses. She noted an increase in the number of publications from 1950 to 1960 and that the main emphasis of most of these related to techniques of program development or program descriptions, and that the research was limited to descriptive surveys or opinions of participants about the programs.

This present review covers the decade of the sixties and found that the calibre of the published literature has changed very little. There are many articles of the type, "How we plan our program" (99), (34), (61), (123), and program descriptions concluding "We felt that the training program was very successful" (117), (71), (84), (104), (58), but there is little objective data to justify these convictions. Indeed, recurring themes are problems such as the rapid turnover of staff, the differing levels and preparedness of nurses, the demands of a busy nursing service, and reluctance of nurses to attend programs (89), (111), (36).

Continuing education as a component of higher education is very recent in nursing. It was generally accepted in the past that the major commitment of the university school of nursing must be to the undergraduate and graduate programs (54). Accordingly, although continuing education courses are reported to be increasing in number (48), the more sequential,

long range programs are the products of a relatively few universities. In the United States, RMPS (regional medical programs funded under the terms of Public Law 89-239), and the Western Commission on Higher Education in Nursing (WCHEN) have also been active in the development of continuing nursing education.

In 1968 Mrs Signe Cooper at the University of Wisconsin held the first national meeting on continuing education in nursing. The primary purpose of this meeting was to provide a forum for the exchange of ideas and developments relative to the field (92). In 1969, concurrent with the Fourteenth Congress of the International Council of Nurses held in Montreal, Mrs Margaret Neylan from the University of British Columbia called a similar meeting (91).

Subsequently, two national conferences have been held specifically for those nurse educators working in the field. The first of these held in Williamsburg, Virginia in 1969, focussed on the leadership role of institutions of higher learning in continuing nursing education (90). The second, held at Syracuse University, New York in 1970, took as its theme the organization of continuing education for the implementation of change (51).

The third national conference held in Wisconsin in October 1971 had as its major theme critical issues in continuing education in nursing. An issue of the Journal of Continuing Education in Nursing (51) was devoted to papers developed around the issues discussed at the conference. In brief, the major concerns as expressed in these papers are as follows:

> Will short term courses presently preparing pediatric nurse practitioners prevent a rapid and necessary increase of the nursing specialist prepared at the graduate level? Present graduate programs are not preparing sufficient numbers of expert nurse practitioners. Can we afford to ignore the need?

> Continuing education is fragmented, disorganized, unrelated and haphazard. Can these activities be co-ordinated in a reasonable rational approach? The great proliferation of opportunities in part reflects an expressed educational need by nurses, but could more be accomplished through better co-ordination?
>
> What are the unmet needs and educational gaps? And whose responsibility is it to meet these needs .... or even to identify the needs?
>
> Who pays for continuing education in nursing? Granted that the learner has some personal responsibility, what about the employing agency?
>
> Does continuing education make a difference? When we can identify more specifically how improved nursing care results from our various educational activities, perhaps we can expect more support, financial and otherwise.

Research Interests

In her report of a national survey of all colleges and University schools of nursing in the United States in 1969, Gwaltney (90) identified the following research underway in the areas of continuing education for nurses:

University of Wisconsin:

1. A Study of The Continuing Learner in Nursing: September 1, 1962 - 1963.
2. A Survey of Inactive Nurses Enrolled in Refresher Courses: September 1967, 1968. (In progress)*
3. Evaluation of the Effectiveness of the Nursing Dial Access Program. (In progress)*

University of North Carolina:

A Study to Determine Whether the Preparation of a Nurse for Coronary Care Has an Effect on the Condition of Patients at Discharge From Coronary Care Unites in the State. In collaboration with the School of Public Health. Dept of Epidemeology and the Regional Medical Program.

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* Completed and available

Syracuse University

Following the programs, Improved Management Skills: An Approach to Better Patient Care: The Dept of Psychology did the evaluation of the program.

St Louis University

Limited local survey of education needs (1965 and 1968). Committee on Continuing Education Study on Evaluation form data, 1968.

Through library research as well as correspondence with over thirty universities in both Canada and the United States, the following additional studies illustrate the nature of current research underway:

A Survey of Inactive Nurses in Washington State. A study to determine the characteristics of inactive nurses, their reasons for not working in nursing, the extent to which they represent a potential nurse supply, and their interest in a refresher course. Sponsored by the Washington State Department of Health; Division of Nursing; University of Washington, School of Nursing; Washington/Alaska Regional Medical Program, 1968.

A Survey of Continuing Education Needs for Health Professionals: Idaho; Montana; Nevada; Wyoming; Sponsored by WICHE/Mountain States Regional Medical Program, 1969.

Nursing in Idaho: A Study of Nursing Needs and Resources; Sponsored by the Idaho Office; Mountain States Regional Medical Program; WICHE in co-operation with the Idaho State Nurses' Association, 1969.

An Evaluation of a Continuing Education Program; WICHE in co-operation with the Idaho State Nurses' Association, 1969.

An Evaluation of a Continuing Education Program in Nursing; University of Colorado, Boulder, Colorado; 1960.

Evaluation of Regional Continuation Education Conferences.

The Effectiveness of a Leadership Program in Nursing; Supported by Public Health Service Grant from the Division of Nursing; Bureau of Health Manpower and Institute of General Medical Sciences, United States Public Health Service, 1967.

Continuing Education for Nurses: A Study of the Need for Continuing Education for Registered Nurses in Ontario; Sponsored by the School of Nursing of the University of Toronto in co-operation with the Division of University Extension, 1969. (25).

A Report of a Questionnaire for Teachers of Nursing in Ontario; A Study of Continuing Education Needs: Registered Nurses' Association of Ontario, 1965.

Continuing Professional Education Needs of Supervisory Personnel in Nursing Service and Nursing Education: Pennsylvania State University, 1965.

Correspondence Instruction as an Educational Method in Hospitals; Pennsylvania State University and the Hospital Research and Educational Trust of the American Hospital Association, 1967 (37).

Management Training Effectiveness: A Study of Nurse Managers; Sponsored by the Texas League of Nursing; 1965.

What Do Practising Nurses Want to Know? A Study of Learning Needs.

As is evident, well over one half of the studies reported are descriptive of nurse manpower resources and the nurses' perceptions of their learning needs. Moreover, most of the reported research on program evaluations are, at best, exploratory.

In 1971, the American Nurses' Association was awarded a one year federal grant to conduct a national survey of continuing education for nurses. The purpose of this project will be to "identify all types of existing continuing education programs and resources" (66). It is hoped that the findings of this study will provide information which will help to determine the future direction for continuing education in nursing.

CHAPTER III

PARTICIPATION IN CONTINUING EDUCATION

Although there is no data available to indicate the extent of nurse participation in continuing education, using membership in the American Nurses' Association as a criteria, Curtiss et al (51) provide a national estimate of less than 30 percent. They stress that the "number of nurses aware of their needs for further study are to be found in encouraging numbers."

CHARACTERISTICS OF PARTICIPANTS

Through an analysis of descriptive data obtained from 314 nurses who attended the University of Wisconsin's Extension courses between September 1, 1962, and August 31, 1963, Cooper and Hornback (28) attempted to identify those personal-professional characteristics of nurses who were more likely to continue their professional education. The results of this study are summarized in this section, using other comparable data where appropriate.

Location of Practice:

Nurses attending the University of Wisconsin extension courses during the period under study were almost exclusively from that state. Those counties not represented in the population tended to be more rural and employed fewer nurses. A recent annual report from the University of British Columbia (100) disclosed similar findings in which 90 percent of the course registrants were from the province, and 65 percent from the Greater Vancouver area.

In a WICHE study (96), the great majority of nurse respondents indicated that "because of family responsibilities, they would not attend short courses offered outside their local communities, even if expenses were paid."

Position in Nursing Service:

The majority of nurses participating in continuing education programs were full-time employees of hospitals. Supervisory personnel made up the largest single group of participants, with some 40 to 50 percent of the participants in this group. Staff nurses were next in frequency at something like 40 percent, with a miscellaneous category accounting for less than 15 percent of the participants. This distribution by position was found in both the Wisconsin study, the UBC Report, and most other similar studies (28) (43) (89) (100) (102). The generalization to be drawn from these data is that nurses in higher positions attend more continuing education programs.

In commenting on this generalization, Cooper and Hornback (28) ask:

> Are the learning needs of supervisory personnel greater than those of nurses on the staff level? Does this suggest that basic nursing programs do not prepare nurses adequately for these responsibilities? Or does this finding suggest that it is easier for supervisory nursing personnel to get away from their job to go to meetings?

Marital Status and Age:

In both the Wisconsin and UBC reports, about one half of the participants were married or divorced. In the Wisconsin study, 45 percent of the participants had children, and one fourth of these had children under five years of age. In contrast, the UBC data found that over one half of the participants had no children.

The Wisconsin study found that the largest percentage of participants were those in the older age group (50 to 54 years). Similarly, the WICHE study found that nurses with ten to twenty years or more of active practice expressed

the greatest need for continuing education. In contrast, the UBC data reveals a distribution that is somewhat equal in all age groups but with a marked decrease in those over 55 years of age.

Educational Achievement:

The Wisconsin study reported that 22 percent of the participants had a college degree in contrast to 15 percent of the nurse population of Wisconsin that had degrees. In the UBC report, 18 percent of the participants had the baccalaureate degree, 3 percent had a Master's degree; and 20 percent a diploma or certificate. These data are consistent with participation studies in adult education which lead to the generalization that participation in continuing education tends to increase with formal education.

Albeit based on a limited sample (N=79), in Shore's study (102) nurses with more education reported less participation in programs of continuing education. She attributed this finding in part to the higher proportion of young graduates in the sample, who "perhaps felt less of a need for continuing education".

Fleck (44) found that variables such as age, educational background, years of experience, and marital status, did not correlate with opinions relative to inservice education. She does note, however, that "in some instances, the years of professional experience did produce a greater recognition of the need for continuing growth."

Use of Other Information Sources:

In the Wisconsin study, over one half of the respondents indicated that they held membership in the American Nurses' Association which contrasted with the 32 percent of the nursing population in the state that reported such membership. Over one half of the respondents

indicated that they read two or more professional journals.

Flaherty (43) found that over one third of the nurses in Ontario felt that their educational needs were not being met yet two-thirds were eligible for inservice education. Flaherty observed that part-time and private duty nurses fared badly in this respect. She also found that nursing library facilities were poor and available to less than one half of the respondents. She also notes that "what was available, was used infrequently by the nurses". Burt's study (16) of 15 hospital staff education programs in Washington state disclosed that only 13 percent of the respondents had done some reading or other preparatory work in conjunction with the inservice program attended (16).

Professional journals and books ranked first in terms of both availability and use, while conventions and meetings ranked second in the WICHE study (96). On the other hand, short term courses were least available but the nurses felt that these were needed urgently. A sample of nurses in each of four mountain states were asked to indicate whether they had received additional formal education or on-the-job training for work in the clinical area in which they were then employed. In all four regions, over 70 percent of the graduate nurses had received inservice education or on-the-job training. Of the three levels of nursing education, 45 percent of the diploma graduates reported that they had received additional formal education in the clinical area compared to 30 percent of baccalaureate graduates and 9 percent of associate degree graduates. The courses most likely to gain support are those which are either based

on what the nurse believes to be her own learning needs or those which she found most helpful in increasing her job proficiency (102), (16), (89).

REASONS FOR PARTICIPATION OR NOT

In the Wisconsin study (28) participants were found to attend courses for a variety of reasons, but none of the respondents attended because it was "demanded" by the employer or for reasons of promotion. The main reasons given for participation were interest, desire to improve teaching or nursing care, and advised to do so by employer.

Family responsibilities was listed as the most important single factor preventing nurses from attending programs of continuing education (37), (28), (43), (122), (96). Other important but related deterrents included time, expense, staff coverage (10), (96), (37), (25), nothing available, and/or distance (96), (28), (43), (57), insufficient advanced notice of course offerings, and/or inadequate publicity regarding the course (25), (28). In the Ontario Survey of Needs (25) employers stated that it was difficult to plan continuing education programs for staff development when little advance notice of course offerings was given. Nurses were reported reluctant to take advantage of opportunities available when costs for attending courses on short notice prohibited its inclusion in the hospital or agency budget.

In her study, Burt (16) found that of the fifteen hospitals polled, four made attendance compulsory at inservice education programs, and one hospital specified that "attendance was required for some, but not all nurses." In the remaining ten hospitals attendance was voluntary. Payson and Salloway (84) found that one of the major reasons staff members did not like the inservice programs was because they were

compulsory. On the other hand, some respondents indicated that once they got there they found the programs enjoyable. Fleck (44) concluded that the major obstacles to participation in inservice education programs were: 1) the rotation of hours and the heavy workload which limited attendance; 2) unplanned, dull, poorly presented programs; 3) the general indifference of the majority of staff nurses to inservice education. These findings are not too different from those reported in the Pennsylvania study (10).

Scheduling:

Most surveys disclose that nurses want continuing education presented in their local communities (69), (57), (36), (122). In the two WICHE:MSRMP surveys over 85 percent of the respondents indicated that they would attend short courses if these were offered in their home communities. The frequency with which they would be willing to attend such courses is shown in Table II.

A survey of inactive nurses in Wisconsin (96) disclosed that of the respondents who were interested in returning to nursing, 73.12 percent desired refresher courses scheduled as part time classes with roughly one half preferring a day time schedule, and the other half an evening schedule; 67.65 percent of the inactive nurses expressed a willingness to travel but one half would not commute over ten miles in order to attend refresher courses. A survey (97) of teachers of nursing in Ontario found that the majority of teachers would like courses scheduled in the evenings and the months most favoured were February and March.

Cost:

In Flaherty's study in Ontario (43), 40 percent of the respondents reported that employers granted them time off or pay to attend programs,

TABLE II

THE FREQUENCY WITH WHICH R.N.'S WOULD BE WILLING TO ATTEND SHORT TERM REGIONAL PROGRAMS

Frequency	Regional Response		Idaho Response	
	Number	Percent	Number	Percent
Once a Month	219	54.88	54	52.42
Every Six Months	102	25.56	30	29.12
Once a Year	47	11.77	11	10.67
Other	31	7.76	8	7.76
TOTAL:	399	100.00	103	100.00

SOURCE: WICHE:MSRMP: Idaho: A Program for Continuation Nursing Education; An Unpublished Report.

meetings and conferences. The most favoured groups in this regard were those in administration, teaching, and public health nursing. In the Wisconsin study (28), three quarters of the respondents had their fees paid by the employing agency. In most cases, this was the entire fee or through time reimbursement in the form of "giving on duty time". Asked if they would be willing to pay their own fees, nearly 62 percent responded in the affirmative while approximately 12 percent responded negatively and one quarter did not respond to the question. Referring to the non-respondent category, Cooper and Hornback ask: "Does it imply indecision or can it be assumed that the majority of these nurses would not have attended the institute had they been expected to pay their own fees?" (28).

Although it is impossible to draw firm conclusions on the basis of the limited data available, a number of reports suggest that many nurses expect some type of reward for continuing their own education. As previously noted, in the Ontario Survey (25), employers reported that nurses were often reluctant to finance their own attendance at courses. In the WICHE:MSRMP surveys (96), only 24.2 percent and 27.4 percent of the registered nurses indicated that they would attend programs outside their own communities at their own expense, whereas 55.8 percent and 63.3 percent would attend if their expenses were paid. Similarly, Goldfarb (46) notes that "most of the nurses who take the course expect compensation upon successful completion", however, "they were not sure where the compensation was to come from or what it should be" (46).

Felt Learning Needs:

Surveys which have used open ended techniques to identify the felt learning needs of nurses reveal some striking similarities in responses. Regardless of position or type of agency, one of the most prominent needs listed is that of improving communication and management -leadership skills (36), (10), (43), (37), (25). Other learning needs rated high in the list of priorities include: newer dimensions in nursing care; legal aspects of nursing; and the changing role of the nurse. In the Pennsylvania study (36), many nurses were being promoted into administrative, supervisory, and team leading positions with little preparation for their new responsibilities, and hence were insecure as managers. Accordingly, directors of nursing were in full agreement that there was an urgent need for courses to improve the supervisory skills.

In the Ontario Survey of Needs (25), employers both of public health and of hospital nurses expressed a similar view. Directors of nursing also indicated that they looked to continuing education courses to fill the gap created by the phasing out of the one year certificate programs on nursing service administration. Other pressing needs revealed in this survey were: 1) courses to increase the teaching skills of nurses in different fields and levels of nursing, including public health nurses, inservice co-ordinators and occupational health nurses; and 2) specialization in nursing, notably in the area of intensive care nursing, chronic disease, mental health, and rehabilitation.

Utilizing a modified survey or "slip technique," Skinner and her colleagues in the Michigan RMP (103) gathered opinions about the current learning needs of staff nurses, team leaders, and head nurses in the care of patients with heart disease, cancer, stroke, and related diseases. Forty-eight nurses representing each level identified not only the broad learning needs referred to in the foregoing surveys, but also specific learning needs directly related to patient care, including 1) how to position acutely ill patients to prevent deformities and other complications; 2) how to read EKG's and recognize death producing arrhythmias; 3) how to be more effective in teaching patients and families; 4) how to care for terminally ill patients; 5) how to care for patients receiving chemotherapy and irradiation.

Using a scaled questionnaire and interviews, Tiffney (109) sought to determine the competencies of general staff nurses functioning in the field of rehabilitation. She concluded that general duty nurses lacked the necessary competencies for effective work in rehabilitation. Although the nurses interviewed emphasized that their role was not understood or appreciated by the other disciplines on the rehabilitation team, Tiffney adds, "this no doubt was aggravated by an apparent lack of understanding on the part of the nurses themselves as to what the functions of the nursing staff include". Among many recommendations, she urged that short term courses in rehabilitation be set up, organized, and implemented by qualified personnel as a crash program to alleviate the shortage of graduate duty nurses who require this preparation to function as skilled practitioners.

In the study of teachers' learning needs (97) over 80 percent of the respondents requested content related to the biological and social sciences. The teachers expressed the greatest need for subject matter specifically related to their own field of practice. As a result of this survey, six 3-week institutes for teachers of nursing were conducted. Although a relatively unstructured program was planned, it soon became evident that the real learning need of the instructors was not course content, but rather how to apply it in situation-type problems in clinical practice (94).

Price (89) attempted to identify learning needs in two ways: The first was a self report of a critical incident encountered the previous year which the nurse considered of extreme significance and related to her lack of preparation. The second was an identification of the learning need which the nurse thought would enable her to best improve the quality of care she provided to patients. Using this approach, Price found that while the nurses reported their greatest learning needs to be indirect patient care, most of the critical incidents related to direct patient care. More specifically, the greatest needs and/or problems related to "insecurity regarding nursing care, new techniques, methods relating theory to practice". Concerning many of the critical incidents reported, she states:

> This indicates a failure of transfer of learning from past experiences. If this does not take place, pre-service education must be considered inadequate. The pre-service education of the individual nurse should enable her to analyze her own abilities and recognize her needs for additional learning (89).

Price indicated that learning needs reported most frequently in the area of indirect patient care were those related to leadership and management. In this area, skill in handling people was given

primary emphasis. It was also indicated that clarification was needed with regard to current programs in nursing education and regarding interpretation and implementation of hospital policies. On the basis of her findings, Price concluded that there was no advantage in trying to group nurses for inservice education according to the amount of professional training received, whether their preservice clinical experience was in the hospital in which they were employed, or on the basis of the number of years away from hospital nursing. She concluded that the homogeneity of learning needs was probably most related to functional role, type of care given, years in nursing, and length of employment.

Methods and Techniques:

A recent survey (10) revealed that the instructional techniques most preferred were: lecture, group discussions, films, handouts, panel, and role playing, in that order. Fifty-eight respondents expressed opinions. One of the most frequent requests relative to improving instruction was more learner participation. Similarly, Burt (16) found that many of the nurse respondents would have liked more opportunities to volunteer comments and engage in discussion with colleagues.

On the other hand, nursing teachers administered a post-institute questionnaire which indicated that the "least helpful aspect of the programs were the small group discussions". The reason given was that "the group wandered from the topic". At the same time, observations by resource persons during the institutes indicated that the development of group discussion and conference skills were a very prominent need among teachers of nursing attending the institute.

The references found relative to the preferences and opinions of nurses about the newer mass media and self instructional methods suggest that nurses are willing to utilize these where available (2), (14). In the WICHE study (96), nurses, particularly younger nurses, expressed an urgent need for programmed instruction, television, radio and educational films, more or less in that order.

A recent survey (10) by the school of nursing at Pennsylvania State University disclosed that 60 percent of the responding hospitals would be willing to experiment with television, while 21.42 percent would not and 18.57 percent were undecided. The major problems relative to its use were: cost, lack of facilities or equipment, and the quality of the program, in that order.

CHAPTER IV

PROGRAM, ORGANIZATION AND ADMINISTRATION

A number of different groups sponsor programs of continuing nursing education including the universities and their schools of nursing, employing institutions - notably hospitals and public health agencies - nursing and hospital associations, and voluntary or specialty health groups. Of these, the universities, hospitals, and nursing associations are the primary sponsors of formal programs.

SPONSORS AND PROGRAMS

Since there is no nationally systematized method for reporting the numbers and types of current course offerings, the information provided in this section represents data gleaned from a variety of sources which reflects present patterns and trends.

Nursing Associations

In a recent article, Spector (105) wrote:

> Continuing education in the American Nurses' Association is like an iceberg. That is, its clinical conferences and publications are clearly visible. What is less evident are the following: the efforts expended by the national association to encourage the development of continuing education programs and make it possible for the profession to determine the standard of its education and practice.

More specifically, the role of the national nursing associations relative to continuing nursing education has been: 1) to procure federal funds for both graduate and continuing education; 2) to encourage the development of effective orientation and inservice education programs in the employing agencies; 3) to promote the return to nursing of inactive

nurses; and 4) to provide information to nurses regarding various alternatives for professional advancement through formal education (95), (7), (105), (86).

In addition to the foregoing, the Canadian Nurses' Association (CNA) provides a Library Loan Service on nursing publications, while the two major associations in the United States offer for rent or purchase various teaching aides and resources. More recently, the National League for Nursing (NLN) is reported developing programmed instruction on various aspects of clinical nursing (118).

In 1967, the American Nurses Association (ANA) received a $50,000 federal grant to promote a nation-wide program of refresher courses to encourage a target of 30,000 inactive nurses to return to nursing within one year. The Association's primary role in this venture was to identify inactive nurses and to involve agencies, particularly state nursing associations, in the provision of the courses. As part of its responsibility, the ANA designed a set of guidelines and a model course which was subsequently published (32). Since this original drive, further grants have been made to expand the ANA's promotional efforts (13).

For the past decade the ANA has been sponsoring three day regional conferences focussed on clinical practice. Although attendance reported at these conferences is estimated at some 950 per conference, one of the principal concerns of the association is whether or not the conference is actually reaching the desired target group, the clinical practitioners. A study in 1967 revealed that the majority of participants were teachers and administrators (105).

The major contribution of the CNA is an extension course on Nursing Unit Administration which it has co-sponsored for a number of years with the Canadian Hospital Association. Designed to combine correspondence study with a workshop, this is offered nationwide to nurses employed in supervisory positions. Generally considered a highly successful program, Goldfarb (46) reported that in the first four years of its existence over 1,500 head nurses, supervisors, and directors of nursing had completed the course.

All three national associations in co-operation with various specialty and local groups offer conferences and workshops relative to continuing education for nurses (25), (118), (105). A major concern of the national nursing association at present is the establishment of guidelines and policies governing the expanding role of the nurse (20), (9). As the health professions move towards "relicensure" the development of standards for continuing education and a greater effort to increase the number of available learning opportunities for practising nurses (105) will require national attention.

This search of the literature yielded little on the activities in continuing education of state, provincial, and local nursing associations. Recent annual reports from university schools of nursing suggest that nursing associations are working more closely with the university schools of nursing both in planning and implementing programs of continuing education at the local level. Their influence is also expressed in other ways, notably through the provision of funds for program development, studies of learning needs, and their role relative to nursing standards and practices (100), (115), (25).

Hospitals

Although there are no detailed studies on inservice education,

the evidence available suggests that its development has been quite limited. One survey of inservice education in nine hospitals reported as part of a national study on the quality of nursing service in Canada (95) revealed that in all nine hospitals studied, orientation to the ward situation was the responsibility of the head nurse and her staff. In a few instances this program was planned to last several days or weeks with conferences, classes, and demonstrations in the afternoons. Three hospitals had a designated inservice educator and tended to offer the more comprehensive programs with more consistent follow-up for each new employee. One major weakness of most orientation programs was the lack of planned orientation to evening and night shifts. On several occasions nurses stated that they had been placed in charge of a ward on evening or nights without sufficient introduction to the administrative functions and procedures, as well as to the patients and their needs. In two instances nurses said they had to depend on nursing assistants and students to inform them of the policies, routines, and responsibilities of various personnel.

In all but one of the hospitals surveyed, planned inservice education programs were provided. However, most of the programs focussed on disease entities, technical procedures, and new equipment, "even though observations and discussions suggested a need for inservice education oriented around the kinds of patients which nursing personnel indicated provided difficult nursing problems." Current literature was almost non-existent on most nursing units; however, one hospital reported circulating select periodicals. Most of the hospitals indicated that nurses were allowed and in fact, encouraged to attend

various short courses, workshops, or institutes, conducted by nearby universities.

The two major administrative problems emphasized by the nurses were: 1) the difficulty of releasing personnel to attend the programs; and 2) the difficulty of planning programs for evening and night staff. As stated by one respondent, "I think the afternoon and night staff should have some form of inservice program, but you can't expect the night nurse to get up for an afternoon meeting".

Many of the critical incidents provided over 1,000 registered nurses in Price's study (89) suggest that comparable problems exist in many American hospitals. This study emphasized that all personnel, whether full or part time, day, evening, or nights, should participate in inservice education and it recommended that scheduling be improved by the provision of an 'education day' for each nurse. "When inservice education is considered as essential, improvement in scheduling can and will be made. This is recognized to be a task that is difficult, but not impossible". The report also recommended that inservice personnel work with nursing service to ensure that nurses not be assigned to a leadership role without previous orientation.

In the Idaho Study (57), hospital based inservice education programs were found to be minimal, and much of what was being offered consisted of didactic presentations. Only six full time educational directors were employed in the fifty three hospitals and fifty four long term care facilities in that state. None of the directors had advanced education nor any additional training in the educational process. In fact, this study concluded that the educator's needs for continuing education were

similar to those of the nursing staff. These findings are not too different to those reported by Tiffney (109), Murray (75), and others (36), (92).

The National Commission on Nursing and Nursing Education (69) summarized its conclusion as follows:

> The entire committment to inservice education has been characterized by inadequate support and insufficient personnel. Of the more than 7,000 hospitals in the United States, for example, no more than 300 have a professional training specialist to direct their inservice programs. All too frequently responsibility has devolved upon nursing service in the absence of any specific plan.

Despite the disorganized state of the field, it is expected that a number of recent developments will greatly influence the future of inservice education. One of these is the recent statement by the Joint Commission on Accreditation which would require that nursing departments provide continuing education for nursing personnel (82). Although limiting in one sense, this requirement would provide greater support for inservice education. Another development concerns the educational media which promise a partial solution to some aspects of the multi-faceted problem (17). Even more important is the increasing trend towards the regionalization of continuing education, which in turn is facilitating cooperative planning andindeed, in some areas of programming, it is becoming increasingly difficult to distinguish between "inservice" and "continuing" education.

Universities and Their Schools of Nursing:

Gwaltney surveyed (49) all colleges and university schools of nursing in the United States. This study revealed that during the academic year 1968-69, 41 of the responding schools offered 400 programs with a range of from 1 to 69. In addition, all 41 respondents indicated

some degree of participation in co-sponsoring courses, notably with voluntary health agencies, state nursing associations, RMPS, and other colleges and universities. The length of the programs offered varied from one half to forty days.

The Ohliger and Barratt survey (81) of 96 NLN accredited schools of nursing offering a baccalaureate but no higher degree suggests even less involvement of collegiate schools in continuing education. Of the 62 schools responding, only 31 had offered a continuing education program during the academic year 1967-68. More specifically, 15 schools offered one continuing education program, 12 offered 2 to 5, and only 4 offered more than 5. These programs varied in length from one day to two weeks while in some cases a program was offered intermittently over a semester.

The University of Toronto Survey (25) revealed that between 1965 and 1968, four of the province's universities provided 19 courses for nurses. Of these, only 12 were sponsored or co-sponsored by schools of nursing. The others were offered by the faculty of medicine and the school of hygiene. The length of the nursing school programs ranged from two days to eight weeks. In the two national surveys, groups for whom programs were most often provided were general staff nurses, head nurses, supervisors, instructors, public health nurses, occupational health nurses, and private duty nurses, more or less in that order.

In Gwaltney's survey, the schools indicated that the most frequent request was for management skills and to a lesser extent clinical nursing. Ohliger and Barratt reported the following content areas: nursing in public health, rehabilitation, maternal-child, medical-surgical, and mental health. More specifically, topics included: sex education and family life, principles of management and supervision, sensitivity training, head nurse roles, legal problems in nursing, teaching methods,

problem-solving and nursing practice, and mental retardation.

A review of recent program descriptions suggests that in addition to the foregoing, university schools of nursing are also offering an appreciable number of refresher courses for inactive nurses (22), (21), (114). The literature also suggests that more consideration is being given to sequentially planned clinically oriented courses, particularly to the areas of intensive care (17) and leadership development (38), (39), (40). In addition, a few universities are reported offering certificate courses designed to expand the role of the nurse in the area of ambulatory care (114), (85).

On the whole, comprehensive programs with long range goals appear to be the exception rather than the rule. As in all the health professions, the great majority of programs in continuing nursing education are short courses, designed to meet the immediate needs of nurse practitioners and/or the employing agencies (18), (116), (48).

ADMINISTRATION

Although administrative arrangements vary, the majority of continuing education programs are administered as part of the universities' schools of nursing. A few, however, exist as separate divisions but within the health science complex (49). At the University of Wisconsin, continuing nursing education is organized as a separate department within the extension division. To ensure co-ordination with the school of nursing, the administrators in extension are also on the faculty of the school. In keeping with the extension concept, courses in nursing are offered throughout the state using a variety of administrative arrangements (26). The University of Colorado's continuing education service has a state advisory committee made up of represent-

atives from various fields of nursing and allied health professions. The role of this committee is to serve as a means of communication relative to continuing education needs, and as a liaison between the school of nursing and health agencies (115).

Gweltney (49) disclosed that the majority of reporting schools employed full time directors of continuing education for nurses. Of these, 27 directors held master's degrees, 4 held doctoral degrees, and one had a baccalaureate. Additional nurse faculty engaged full time ranged from 3 to 23. Most of these held master's degrees. Ohliger and Barratt (81) reported that 7 of the 31 responding schools reported that persons responsible for the program had some additional preparation in adult education.

Instructors

The nursing schools reported the use of both regular faculty and outside people to teach continuing education programs. These latter included: public health personnel, nurse clinicians, physicians, physical therapists, sociologists, psychologists, social workers, pharmacists, attorneys, and television programmers (81). Most schools also report the use of local nurses as resource persons and/or teachers (92). Some schools report the use of patients and families as important and effective resource persons (100) (79).

The recruitment of faculty, expert both in the field of nursing and the psychology of adult learning, has been identified as one of the major problems in selection of teachers (100), (90). Another is the heavy responsibilities which the regular faculty carry in the undergraduate and graduate programs. The policies of some universities prohibiting payment to faculty members participating in continuing education programs

is said to further aggravate the situation (92).

Recent literature suggests that many university schools of nursing are attempting to meet the acute shortage of skilled adult educators through intensive training courses for nurse faculty, inservice coordinators, and public health nurses (38), (39), (40), (41). In addition, at least 2 RMPS have engaged full time personnel to assist inservice educators to improve their programs and to prepare local nurses to plan and implement programs of inservice education (24).

Finances:

As in the other health professions, continuing education in nursing has been the recipient of grants from the Kellogg Foundation (115), (100), (19). Other sources of funds include donations, course fees, professional associations, employing agencies, and government grants (27), (115), (66). University schools of nursing in the United States appear to be in a much more enviable position than those in Canada. In fact to date, medicine and nursing have received the lion's share of funding for continuing education through public law 89-239 (23).

Other lucrative sources of revenue in the United States have been the federal short term training grants through the Manpower Training Act (66), the NIMH (National Institute of Mental Health) grants (119), and the twelve month grants through the U.S. Public Health Service, Division of Nursing (83). Despite such a diversity of sources in the United States as in Canada funding is said to be inadequate (116), (90). The main problem seems to be a shortage of funds for continuing education which requires a secure financial base. In fact, the pace setting schools of nursing appear to be those which have had considerable financial support from the university (115), (26).

Publicity and Promotion:

The promotion of continuing nursing education is achieved through the usual brochures, nursing association newsletters, newspapers, and nursing journals. Of these standard methods, the Wisconsin study (28) found that brochures and fliers sent to hospitals and other employing agencies were the most effective means of reaching nurse practitioners.

In order to facilitate advanced planning by the employing agencies and nurse practitioners, some universities are publicizing their program offerings once a year in the form of calendars (18), (114), (100). Since January 1971, the Journal of Continuing Education in Nursing has included an "Educational Opportunities" section as a further aid to those nurses interested in attending programs both within and without their state.

As in dentistry, it is not unusual for course sponsors to offer credits or certificates for course attendance. In Gwaltney's survey (49), 7 schools of nursing reported offering credits while 25 did not. Credit was used most often by schools offering extension work in some courses unrelated to degrees.

Program Planning:

Most of the university schools of nursing use permanent or rotating committees to assist with the overall planning. Committee members usually consist of both school faculty and outside resource persons. In addition, special committees are organized to plan individual program offerings (115). The personnel in these planning groups are selected on the basis of their expertise and interest in the particular program being planned (100), (115). Reports on inservice education suggest that most programs use committees for planning (45), (42), (87). In the CNA survey (95) it was found that general staff nurses and nursing assistants in some

hospitals each appointed committees to plan programs for their own groups.

As in medicine and dentistry, nursing appears to make extensive use of participants' opinionnaires as a basis for program planning. However, as in most fields of adult education, these surveys do not identify the participants' real learning needs (92). Straub (107) found that even when the nurses selected the content, helped plan the program, and had time provided so that they could attend, more than one quarter of the nurses did not attend the majority of the meetings. She also observed that attendance was much lower for those meetings devoted to nursing care and interdisciplinary matters. Straub asks:

> Should the content for inservice education programs be determined by the nurse practitioners? Or should additional topics be suggested by people in leadership positions such as the head nurse, supervisor, and director of nursing service? Persons in these positions might have a different concept of the needs of nursing personnel because of their postions, experience, education and the like?

Grosicki (47) surveyed needs in one Veterans' Administration Hospital and found that while many different viewpoints had been incorporated into the carefully planned programs, most of the activities met the immediate needs of the situation, but were lacking in continuity and overall program goals. Primary emphasis had been placed on functional competence, particularly the efficient management of the unit, and "this area showed the greatest increment of application. In other subject areas, very little of what had supposedly been learned had been put into clinical practice. The greatest deficit appeared in clinical competence."

In a similar vein at the Williamsburg conference (90) it was agreed that the two most serious deficiencies in continuing education were: 1) the lack of continuity between knowledge and its utilization and, 2) the problem of unmet and unidentified learning

needs. More recently, under the auspices of the WICHE:MSRMP, the Committee of Continuing Education for Nurses in Idaho (120) has drawn up a proposed program based on the philisophy expressed by Miller:

> It would seem that the time has come to try a different educational model .... one built upon solid evidence about the way adults learn, rather than upon the time honored methods of teaching them. There is ample evidence to support the view that adult learning is not most efficiently achieved through systematic subject instruction, it is accomplished by involving learners in identifying problems and seeking ways to solve them ....

In keeping with this philosophy, this program will be introduced in phases with the major emphasis during the first phase on the learning process. Group meetings in the clinical areas will be utilized with active involvement of the participants in analyzing and determining their own learning needs, and with instructors available who will be working with several groups simultaneously. Content material will be provided as the groups are ready for it. Existing resources will be used as required. Several instructional processes will be used in response to the needs expressed by the participants. As the programs develop they will be regionalized and ultimately integrated with continuing education programs for physicians and allied health professionals.

Continuous evaluation will be built into these programs through the use of objectives stated in behavioural terms. Participants, faculty, and the agencies where nurses are employed will participate in the evaluation of the project. More specifically, the evaluation will attempt to: 1) appraise the participants' ability to identify their own educational needs and to establish goals for sustained 'self education' through the use of available resources; 2) determine the extent to which

the quality of patient care has improved and to what extent the facilities support continuation of the program, and 3) a general analysis by the faculty of the co-operative approach to continuing education and its value to participants and their employing agencies.

SOME SAMPLE PROGRAMS

It is difficult to generalize about the instructional processes currently used in continuing nursing education. Nevertheless, a perusal of recent program descriptions suggests that a high premium is placed on small group discussion, hence it is not unusual for university schools of nursing to control enrollment, both in terms of numbers and according to such variables as area of specialization, position in the employing agency, and on occasion, years of experience (38), (39), (40), (41). The most promising approaches appear to be those which have managed to combine the classroom instruction with clinical practice.

Regional and Sub-Regional Programs:

In 1957, the Western Commission on Higher Education in Nursing (WCHEN) launched a centrally planned, regionally implemented leadership training program for nurses already employed in key positions. Financed by the Kellogg Foundation, the primary objective was "to aid the participants to become more effective leaders thereby improving patient care".

Several features distinguished this course from other previous efforts. It was scheduled on an intermittent basis, consisting of one week conferences separated by 3 to 6 months intervals extending over three years. During the interim periods the participants

returned to their work settings to apply what they had learned, with consultation services available as requested. In this way nurses who ordinarily would not have been able to engage in further education were able to do so. Another aspect of this program particularly conducive to learning was the in-residence conference which took participants away from the work settings where they could freely exchange ideas and progress notes on problems in their home situations. Encouraged by the favourable response to this experiment, a grant was received from the Public Health Service, and the program continued (29).

Since the initial project, various alterations have been made in the program with the time span reduced to two years and, in some cases, one year. Techniques of instruction now include lectures, panels, small group discussions, and clinical experiences. To facilitate the application of new learnings, each participant selects some area of work in which she wishes to bring about change which she undertakes as a take-home assignment. These are discussed at the initial session and progress notes reviewed at subsequent sessions, both individually and in groups (68). Continuing evaluations have utilized a variety of techniques including observations of simulated nurse-patient situations, analysis of process recordings and diaries, rating achievement of course objectives, satisfaction ratings such as the Kropp-Verner scale, and Firo-B, which is a measure of group compatability (31). This program design is widely used in continuing nursing education. Most of the programs reviewed or mentioned in this section are replicas or modifications of the original WCHEN model.

Despite its successful application, and the high regard with which the WCHEN leadership programs are viewed, success has been difficult

to measure in terms of behavioural change. Between 1962 and 1964, eight WCHEN programs were objectively evaluated using a variety of paper and pencil tests, scaled ratings of observed nurse-patient situations, and employer-employee ratings on the job. Four hundred and ten course participants and 450 non-course participants were examined on their before and after interpersonal relationships as well as other changes in behaviour. Although the evaluation found that the course significantly influenced participant attitudes and beliefs, no firm conclusions could be drawn with respect to actual changes in behaviour (60). An earlier, albeit less well designed study by Todd (110) disclosed similar findings.

Using the WCHEN pattern, the Texas League of Nursing sponsored a similar series of regional conferences for management personnel between 1960 and 1964. An evaluation of this series revealed findings consistent with those of the WCHEN studies. In brief, although the participants appeared to adopt a more democratic and understanding attitude, there was little conclusive evidence to suggest a change in job performance (72).

Commenting on the WCHEN findings, Ingmire (60) raises a number of crucial questions:

> How can the quality of nursing care be measured? What other instruments can be developed to measure nurse behaviours in the work setting? How can participants for future programs be selected who have the greatest potential for personal growth? How can the participants' learnings be extended into institutional systems more effectively? How can institutional administrators and colleagues of related disciplines be more closely involved in this or similar programs?

In an effort to tackle the multi-faceted problem of the institutional climate, Ingmire and her colleagues at the University of

California have extended the WCHEN leadership focus to many of their continuing education programs. Ingmire and Blansfield (59) have recently described one such program in which hospital administrators, directors of nursing, and deans of schools of nursing enrolled as teams "to learn new and revised theories of team building and to consider ways in which these theories could be applied in the back-home setting". The program consisted of three day conferences meeting three times over a one year period, which provided the teams an opportunity to utilize and reinforce conference learnings. The training laboratory or "T" group approach was used with theoretical material presented as needed but mainly to provide a focus for discussion and interaction among participants.

An evaluation of the program was conducted in two ways: 1) participants' perceptions of change in themselves and in their relationships with others; and 2) faculty's perceptions of change in the participants' method of interacting during the course of the sessions. Of the 39 participants who completed the first series of conferences, 27 responded to a questionnaire and the most frequently reported behavioural changes were increased understanding of themselves and others, and more open relationships. Of the reported changes in organization and management processes, improved meetings was mentioned most often. The most tangible evidence of the success of the course was the participants' request for an advanced training laboratory which has subsequently been implemented with high enrollment reported.

Brown (16) has reported a three year pilot project in which teams of instructors and supervisors were enrolled for a course on cancer nursing.

Co-sponsored by the Southern Regional Education Board (SREB) and the University of Texas, this course consisted of three conference sessions extending over a one year period. The major emphasis was on the nursing care of patients and families. The sessions also stressed and demonstrated the multi-disciplinary approach. One of the major take home projects was the development of a plan for extending the knowledge and skills participants had acquired to other nurses in the back home setting.

Although well conceived, Brown reports that many difficulties ensued in the implementation of the program. Because this type of an educational experience was so new to most of the participants, and because they had such varied backgrounds, instruction had to be provided on an individual basis frequently. The greatest problem related to those assignments requiring participants to engage in direct nursing care. Both the instructor and supervisor participants were found to be psychologically insecure and reluctant to communicate with patients and families.

Truscott and Keller (112) have described an interdisciplinary program in use in the North Carolina RMP stroke program. This four day course is offered in two day units with a week in between. Content identified as pertinent to all participants, physicians, nurses, physical therapists, speech therapists, occupational therapists, and medical social workers, is presented through joint session. Instruction includes lectures and discussions supplemented by slides, films and filmstrips. Also provided is a loose-leaf notebook with review notes pertinent to each discipline. Four such courses have been completed with an attendance of 154 professional health workers. As a result of this experiment

it is felt that the basic core content has been identified and that the participants are developing a better understanding of the meaning of rehabilitation and their interrelated roles in the management of the stroke patient.

Truscott and Keller (112) reported that great gaps were found to exist in the participants' knowledge of the care of the stroke patient which posed a real problem as did the associated unlearning which was necessary in some instances. Although participants were identified as a "stroke team", the team concept as an approach to care was often not understood or implemented. In joint sessions, physicians were reported hesitant to ask questions because nurses were present, and nurses were equally reluctant to expose gaps in their knowledge. Some participants were facility rather than discipline oriented in that their interest in stroke patient care was limited to its application in their own particular type of facility. Thus public health nurses were not interested in acute nursing care and nurses employed in acute hospitals were not interested in the community aspects. Similarly, participants from small rural communities were not interested in hearing or discussing facilities which were not available in their own home settings. Generally speaking, "Health practitioners were more interested in the "how to" rather than the "why" or the philosphy of care".

In a recent article, Conley and Larson (24) report that the Colorado RMP and the School of Nursing are offering an interdisciplinary course in Rehabilitation and Maintenance. This program is intended to develop skills needed for "post crisis" patients and it is offered in small rural communities throughout the region. Local planning committees composed of representatives from nursing and the allied health professions identify educational needs and develop the program with the assistance of

university faculty. Local health personnel are utilized as instructors with the university providing assistance as necessary. The course is highly individualized in terms of local needs and the needs of participants as well. Scheduled on an intermittent basis, the program consists of three 3-day conference sessions. Following the initial session, the participant selects a patient for whom she develops a nursing care plan. In the period between the second and third sessions she is asked to develop a teaching program for her selected patient. Instructors provide individual guidance to students throughout and each is encouraged to proceed at her own pace.

Conley and Larson (24) also report that the Western Pennsylvania RMP and the Graduate School of Public Health at the University of Pittsburgh are conducting a program for the long term training of nursing home personnel, using both university and in-patient facilities. The course consists of weekly sessions lasting one day for a nine month period. Formal presentations are minimized in preference to problem-solving. Where possible administrators and charge nurses have classes together. Following the completion of the program the participants are provided with consultation services by the faculty for a two year period.

According to Conley and Larson, the effectiveness of this course is demonstrated in the patient care facilities to which the graduates have returned. They cite new and improved nursing procedures that have been instituted in the home facilities, the establishment of positions for both a director and an inservice educator; job descriptions and performance evaluations for nurses have been developed, and inservice programs have been implemented in a number of facilities.

The MSRMP (Nevada) is using a Consulting Team approach to continuing education for health service personnel in rural communities in Nevada. The core of the consulting team consists of physicians and nurses with other health professions serving as resources where their skills are required. A bi-monthly schedule of visits provides consulting service to local communities. The program for each visit is based upon the identified needs of the community and is developed co-operatively with the health personnel in each area to be visited. Thus the team may provide either structured courses or unstructured consultation depending on the need.

The ever increasing demand for nurses with specialized skills in intensive care nursing, and more particularly, coronary care, has resulted in a great proliferation of short courses in this area of nursing. Of the many program descriptions reviewed, the one sponsored by the Colorado-Wyoming RMP and the University of Colorado School of Nursing (114) is probably the most comprehensive and well integrated. Scheduled on an intermittent basis, the initial two week session consists of lectures, self study, and practical experience followed by a six week interim in the participant's own work setting. During this period the trainee completes a special assignment "which involves identifying a problem in her clinical setting about which she develops a research-type project directed toward a solution". The second two week in-training session places considerable emphasis on clinical experience which is largely individualized to meet the individual's own particular employment needs. The last two days are devoted to management and co-operation between health personnel in clinical settings. For this last session, participants are encouraged to invite directors of nurses, hospital board members,

hospital administrators, or others of her choice from the home hospital. Thereafter, a one week follow-up session each year is available to ensure the necessary updating of information and an evaluation of the program's effectiveness. Concurrently, the University of Colorado is offering a course on the intensive nursing care of children as a companion to the course on intensive care of adults. The sessions are conducted together where the two courses have material in common. In addition to the behavioural and physiological aspects of nursing care, this course emphasizes the nurse's role with the total family group and the team approach to patient care in the intensive care unit.

Inservice Education:

Del Buerno et al (33) described a special orientation unit with its own instructor and a head nurse particularly responsive to the needs of staff at the Presbyterian Hospital in New York. New staff members are rotated through this unit to receive necessary instruction and experience on all three shifts under the guidance of an instructor or charge nurse. Although it is too early to evaluate the overall effects of this plan, it is thought that this program will help ultimately in decreasing the high turnover rate of nursing staff.

At Peter Bigham Hospital in Boston (103), nurses with less than six months experience are being rotated through two clinical specialties following a six month period in medical surgical nursing. Programs of inservice education are provided concurrently with these new experiences. In spite of the difficulties in implementing such an ambitious plan, the advantages are felt to be: 1) the nurse received a year of planned experiences during which time she has the opportunity to consolidate her medical surgical nursing skills and to sample two kinds of specialized

nursing; 2) there is evidence of increased morale among the nurses: and 3) nurses are available to relieve in specialties when necessary.

At the University of Rochester's Strong Memorial Hospital (70), instructors have been assigned to each of the major clinical services which has made possible unit based clinically oriented inservice education and more individualized orientation programs. On the first day each newcomer completes a questionnaire which asks about past experiences and felt learning needs. Through an analysis of the information gleaned from the survey an individualized clinical orientation is then provided as part of the overall program.

Wilkinson (121) has reported an experiment in orientation at the Langley Porter Neuropsychiatric Institute of the University of California in which new psychiatric nurses engage in self-orientation. In this experimental project, the environment was structured to make available selected learning opportunities and the nurses were informed about them but no attempt was made for structured learning activities. The only specific requests made of the new staff member was that they tape a report at the end of each day which was a resume of the day's activities, and they were asked to inform the school when they terminated this self orientation. Findings revealed that the orientation was highly individual, with no two nurses proceeding in the same manner yet all of them involved themselves in those activities which they considered significant to their orientation. From the tape recordings it was apparent that as the days progressed, the nurses became increasingly aware of what they must learn in order to function as well as others. This procedure was identified as the "self identification of continuing learning needs".

At the Loeb Center for Nursing and Rehabilitation in Montefiore, New York (3), the new nurse is assigned directly to the unit to work with a staff member who is thus available to her for help as she identifies a need or expresses an interest. Opportunities for conference are also available where she may receive clarification on matters of policy and/or procedures. Through this program the newcomer is encouraged to identify her own need for help and is given the time to plan her own orientation. The inservice education program at the Loeb Center is probably one of the best examples of how continuing nursing education can be built into day to day practice. Staff conferences scheduled once a week for all nurses involved in the program provide opportunities for group discussions about ways to facilitate care and to clarify varying types of problems which nurses identify as interfering with their work with patients. Unit conferences are held as the need arises and nurse to nurse reports from day to evening shifts are described as "conferring, planning sessions", rather than the usual recitation of activities.

Regularly planned conferences and teaching on the wards also typify much of the inservice education at Rancho Los Amigos Rehabilitation Center in Los Angeles (16). In addition, workshops on rehabilitation nursing are also scheduled regularly. These courses are available to nurses from general hospitals, special long term hospitals, nursing homes, visiting nurses associations, and public health agencies, as well as the staff at Rancho Los Amigos. Interdisciplinary in approach, some of the sessions include selected patients who present pertinent aspects of their case histories and discuss their perceptions of the treatment process.

Of the growing number of programs preparing pediatric nurses, the one at Bunker Hill Health Center in Massachusetts (11) best fits the definition of continuing education used in this report, hence a description of this program is provided as an example of an innovative program designed to expand the role of the nurse. In 1968 a sixteen week program was started which allowed a nurse to continue her regular schedule but with a minimum of one and a half days per week release time for the duration of the course. Admission requirements were: 1) that the nurse trainee already hold a job or have promise of a job with a practitioner who provided pediatric care for all children in the family; 2) each trainee be guaranteed the opportunity by her employee to function in an expanded role in her work setting; 3) on the job training be provided by a qualified pediatrician during the course; and 4) opportunity for on the job training be assured following completion of the program. No special educational qualifications were required other than successful graduation from an accredited school of nursing.

The course was divided into 94 hours of classroom instruction, and 96 hours of clinical practice in a variety of in-patient and pediatric ambulatory settings. Clinical practice also included specially arranged experiences in the nurse's own work setting under the preceptorship of the pediatrician and the supervision of the Center's nursing faculty. Through seminars and individual supervision, the following factors were emphasized: 1) the decision-making process 2) conflict and anxiety in role re-orientation; 3) team work and interpersonal relationships; and 4) the problems of delivery of health services to children and their families.

Since the first two courses were considered experimental, no attempt was made to make an objective evaluation, however, certain personal-professional characteristics were tabulated. This disclosed that roughly one half of the participants had a diploma, approximately one third a baccalaureate, and five had a master's degree. About one half had had no prior pediatric or public health nursing experience, and most of the rest had less than five years experience in either field. In short, they were a relatively inexperienced and youthful group. Concerning these data, the authors note: "In our experience nursing education background has had no relationship whatsoever to successful and satisfying function in the role of pediatric nurse practitioner. The same can be said of age, marital status, and number of children". They do point out that certain areas of content were weak, notably child growth and development and knowledge of common pediatric problems. They also felt that more time was required for the nurses to work through the problem of conflict and anxiety related to role re-orientation. This program has recently become associated with North Eastern University, which, according to Brown (16) "should provide the depth required to develop the kind of leadership needed to change the health care system".

Mass Media and Self Instructional Methods:

Since the completion of the statewide educational television network in Kentucky, along with the other health professions, nursing has been presenting programs on PANMED, and interprofessional television series. From November 1969 to November 1970, nursing presented eight programs in this series. A survey (14) based on 587 questionnaire responses (66 per cent of the registered nurses in Kentucky) disclosed that the majority of nurses watching the series were young graduates from

diploma programs working general duty in hospitals. The overall reaction to the programs was favourable, with many respondents indicating that they felt PANMED programs could be used by nurses to continue their education. The major criticism of the series was a lack of knowledge about the program. More specifically, 174 of those who did not watch any of the series indicated that they did not know it was to be shown, and another 33 "thought it was a refresher course for nurses". The second major complaint expressed by those who watched was that the reception was poor, with 98 reporting that they were unable to get the series.

On the basis of these findings, it was recommended that the series be continued, but that some method for evaluating its effectiveness be instituted. It was also recommended that the series be advertised better, and that it be shown at an earlier time. It was further suggested that the programs be made available through closed circuit television in the public colleges; "These could then serve as centers for feedback and evaluation of some of the programs offered".

Abbey et al (1) reported an experiment using open circuit television in which they sought to determine whether nurses gained more from a broadcast viewed individually at home or from one viewed with a group of colleagues in a hospital conference room. They also attempted to identify those conditions which enhanced learning compared with conventional broadcasts which require no active participation. In this experiment, three response conditions were used: 1) the control condition or conventional broadcast presentation; 2) experimental conditions consisting of a "covert" presentation in which questions were inserted into the broadcast with students encouraged to think of the answers for themselves; and 3) an "overt" condition in which the

students were rewarded for making a written response to the questions by being provided with knowledge of results by return mail. Participants included 120 general staff nurses drawn from each of three geographically separated cities which participated in the study. In each city, 20 respondents viewed the offerings individually at home, and 20 did so in a group setting.

The program was sponsored by the University of California School of Nursing as a tuition course which carried a certificate of completion. Learning achievement was measured by a sixty item multiple choice test, while attendance was measured in two ways: 1) subjects who completed the course indicated on a special form which programs they had viewed; and 2) actual attendance of subjects in the hospital setting was recorded for each broadcast. The findings revealed no significant difference in regularity of viewing and completion of the course according to presentation response conditions. Although the results on the presentation response conditions were statistically inconclusive as measured by test results, home viewing was found superior to group viewing as measured by learning achievement. The report concludes:

> If only group viewing at central location were effective, broadcast television would have limited instructional potential. The findings of this study indicate, however, that through home viewing, broadcast television has the potential to serve all health science professionals, including those in which members spend their working day separated from each other".

For the past several years the University of California School of Nursing in Los Angeles has been offering televized programs via the scrambled network system. The series is presented on the Medical Television Network to 70 member hospitals. Nurse co-ordinators in each of the hospitals are assigned responsibility for publicizing the programs, organizing the viewing facilities and introducing and conducting a

fifteen to twenty minute discussion following the program. Approximately 13,000 nurses and members of other health disciplines are reported to have viewed the series.

The programs are patient centered and frequently have used actual patients as well as health personnel with emphasis on demonstration. Squaires (106) identified the major problems encountered in the first five years of the program: 1) poor selection of program chairman; 2) too much content; 3) not enough depth in content; 3) no permanent staff; 4) no money for implementing programs as part of the continuum of continuing education offerings. She also reports that portable equipment is being taken into the field for live conferences and that this approach has been found effective in developing counselling interviewing techniques.

The Ohio State University School of Nursing and the Department of Nursing Services of the Ohio State University Hospitals (80) are broadcasting two-way radio telephone programs to 48 of the state hospitals to enable scattered audiences to participate in programs of continuing nursing education. Attendance is reported to have increased from some 2,000 during the pilot project in 1966 to over 10,500 for the 1969-70 series.

The programs consist of a lecture or panel presentation followed by questions and comments from the participating hospitals through their moderators. Each hospital is furnished a quantity of printed outlines and a set of 2 x 2 slides which are used in conjunction with the presentations. "Interest and enthusiasm" for the program is said to be a motivating factor in the continuation and expansion of the series.

In 1966 the University of Wisconsin (52) initiated the first statewide telephone conference for nurses. Fashioned after the telelecutres developed for continuing medical education, this series was offered as a lecture followed by a question and answer period. The 12 classes presented weekly were received at 24 centers located in various clinics and hospitals throughout the state. Co-ordinators assumed responsibility for showing accompanying slides and serving as moderators. Since the original series, improvements in technology have made possible simultaneous transmission on FM radio. There are presently 56 telephone listening posts, and 27 radio listening posts, with about 1000 Wisconsin nurses participating in this weekly series.

On the basis of a 20 percent return (N=209) of evaluations for the 1967-68 series, Hornback (92) reported: 1) the majority of the participants were currently employed in nursing; 2) for approximately one half of the respondents the telephone conferences comprised the first continuing education program attended; 3) most respondents felt satisfied with the programs but many thought that there were too many.

Since 1969 a special radio-telephone series has been offered for inactive nurses in order to help them keep up to date on general nursing knowledge. Funded by the Wisconsin RMP, this series is but one facet of the Wisconsin Inactive Nurse Service (WINS). Another is a project in which independent study guides are being developed on a number of topics requested by inactive nurses (2). Yet another innovation pioneered by medicine and which nursing now shares is the dial access library (77). Nursing Dial Access was initiated in 1969 after a four month trial period. It consists of a number of pre-recorded five to seven minute audio tapes on a variety of nursing subjects. The nurse

dials a special telephone number and asks for the tape she is interested in hearing. The record is then played for her over the telephone. The service is available without charge to all Wisconsin nurses. A recently completed evaluation of the program found that more than one thousand calls are being received per month, with two-thirds of them between noon and midnight; nurses in more rural areas utilize the service more often than do their urban counterparts; hospitals, nursing homes, and schools of nursing make the greatest use of the program (104).

In view of the many problems confronting inservice education, it is surprising that greater use has not been made of the newer educational media and, more particularly, self instructional methods. The only innovative program reported was that described by Lindeman and Aernam (67), which was conducted at Luther Hospital in Wisconsin. Using a portable slide/sound projector, the nursing staff at this hospital are developing their own self-study packages on various nursing procedures.

Dubin, Marlow, and Alderman (37) surveyed the use of correspondence courses in hospitals. They found that hospital administrators and department heads in the United States generally lacked information about this method and that it was rarely used for inservice education. On the other hand, hospital administrators in Canada were found to make fairly extensive use of correspondence courses for their employees. With the exception of the CNA-CHA Extension Course on Unit Administration, this review found no descriptive studies on its use in either country, and the same was true for programmed instruction.

RECURRING ISSUES AND TRENDS

The issues confronting nursing education are not too different from those facing medicine and dentistry; however, continuing nursing education is faced with some unique problems related to the ambiguity surrounding nursing, as well as the need to "upgrade the education of nurses who have graduated from programs which differ widely" (51). Adding to the confusion has been the recent emphasis on the expanding role of the nurse. Nukoll (78) reported an analysis of a recent mailing from the American Academy of Pediatrics which found that 24 of the 34 training programs listed for pediatric personnel were designed to admit nurses. Of these, only 6 required a B.S.N. degree for admission. The duration of the programs ranged from 16 weeks part-time to 18 months full-time culminating in a master's degree. These data suggest that there is as yet no consensus on the educational preparation of pediatric nurse practitioners. In the meantime, Hutchison (56) has warned:

> There is imminent threat of crash programs developing outside the educational mainstream. The preparation of the pediatric nurse associate falls squarely within the generally accepted scope of continuing education since the programs seek to further prepare the practitioner nurse.

She urges that continuing education faculty ensure that the minimum standards outlined in the guidelines for Pediatric Nurse Associates be followed and that leadership be exerted to ensure that sound programs develop under the sponsorship of university continuing nursing and medical education.

As noted earlier, Cooper (48) has expressed concern from another point of view. She queries whether short term courses preparing physicians' associates "will prevent a rapid and necessary increase of nurse specialists at the graduate level". Related to this problem is

the question as to whether continuing nursing education should make special provision for the granting of credits toward college degrees in an effort to enable the vast number of experienced and capable nurses to obtain recognition for their clinical capabilities. On this issue, Squaires (21) has advanced this view:

> Continuing education should facilitate the passage from one level to another without lowering standards. This can be done by careful study and re-designing of curriculum. Keeping standards at the forefront but not allowing tradition to dominate, continuing education should be involved in the planning and provision of courses to move people along the way.

Even as these issues are beginning to be seriously discussed by nurse leaders, nursing like all the health professions is moving in the direction of mandatory continuing education as a requisite for practice. In 1970, the California Legislature passed a bill which specifies that after January 1, 1975, nurses and other health professionals will be required to submit proof that during the preceding two years they have informed themselves of developments in their fields, either by successful completion of examinations, or by pursuing an approved course or courses of continuing education (65).

At the same time, nurse educators are unanimous in agreement that should mandatory continuing education be implemented, colleges and universities could not produce the required courses at present (51). Indeed, with the exception of a few universities and regional efforts to develop continuing education programs from the perspective of long range co-ordinated planning, continuing nursing education has been described as "unrelated, ad hoc measures, lacking continuity and follow up" (92).

CHAPTER V

SUMMARY

Registered nurses are the largest single group of health professionals. This group is made up largely of women, of whom well over one-half are married, and approximately one fourth of the group is employed part-time. There is a large inactive group of nurses, many of whom would be willing to re-enter the work force. Entry into the profession is achieved through either a diploma or a degree program but the vast majority of nurses have no academic degree. Where private duty nursing was once the major field of employment, over 83 percent of the employed nurses are now working in hospitals and nursing schools.

The role of the nurse in patient care is in a state of flux with the new role not yet clearly defined. As it emerges, the trend is toward expanded responsibilities both in general nursing duty and in specialization. This is creating new dimensions to the knowledge required to perform new or modified tasks in patient care that results in the need for systematic learning at all levels within the profession.

There have been four major developments in nursing over the past decade. These are: 1) a re-orientation of graduate nurses back to the bedside; 2) a trend toward clinical specialization; 3) an increased effort to define nursing practice through research into patient care; and 4) changes in the reciprocal roles of physicians and nurses. Inservice and continuing education have been identified as important vehicles for facilitating these trends, and indeed, for solving many of the problems in nursing.

While the identified learning needs relative the broader areas of nursing are not at all surprising, a number of studies indicate that

nurses at all levels are insecure in their present positions and that they are concerned regarding their future in nursing. Furthermore, the few studies which have attempted to determine not only what nurses believe they need, but also their real learning deficiencies, suggest that the learning needs of registered nurses are numerous and diverse.

While inservice education offers the greatest potential for the development of clinical competence, its potential has hardly been touched. On the other hand, although continuing nursing education at the university level is in its infancy, it is faced with some extraordinary demands, which the majority of schools cannot cope with at present, neither in terms of faculty, facilities, nor finances. What is required, therefore, is a clearer delineation of respective roles of the university schools, the employing agencies, and the professional associations who are the three major sponsors of continuing education in nursing. More specifically, in view of the evolving trends in nursing, it would seem that the university schools should focus on the development of leadership and consultant services to the employing agencies rather than investing scarce resources in short course offerings which at best only serve to meet the pressing needs of the moment.

Continuing nursing education should exert leadership in the development of new instructional materials and program designs. As noted by Conley and Larsen (24), most of the innovative programs in nursing funded through public law 89-239 have been innovations in organization and administration rather than in educational design. This is equally true with respect to most of the other innovative programs described above.

Joint planning and the co-ordination of resources at all levels are also indicated. In addition, the health professions might profitably pool resources and work together in developing clinical programs, for as amply demonstrated in this review, some of the most "successful" programs in nursing have been those which have been developed within the framework of a health team approach.

In order that continuing education in nursing can achieve the learning and changes in behaviour that are required by the expanding role of the nurse in patient care, it is necessary that educational programs be developed that are functionally efficient as instruments for change. This can only be accomplished through the design and management of programs that are geared to adult learning. Among the several health professions, nursing has been the first to accept the need for specialized skill and knowledge in adult education as a pre-requisite for educational planning. As this trend continues, it will provide the profession with a cadre of skilled educational specialists to ensure that continuing education programs will meet the need for learning in the progession.

CHAPTER VI

EPILOGUE

Continuing education in the four major health professions has become a matter of growing concern that somewhat belatedly follows the need to keep abreast of expanding knowledge and the demand for better health care. Among these four professions studied, medicine is far in the lead with respect to the quantity of educational activities available to the members of that profession. It is followed in turn by nursing, dentistry, and pharmacy in that order. Each of these fields has approached continuing education differently with respect to the acceptance of the need for education, the resources committed to it, and the kinds of learning activities provided.

In none of the professions is there evidence of a real commitment to continuous learning by its members nor is there any substantial evidence of a real understanding of the educational process. The activities made available tend to be too few in number to meet the need, too poorly distributed to be generally available, and too poorly planned and conducted to insure that learning does in fact occur. Medicine has consistently committed proportionately more resources to continuing education than has the other health professions but nursing appears to be sensitive to the educational process as it applies to continuing education programs. Furthermore, there has been little research in any health profession to find the extent to which existing programs affect the practice of the members of the profession.

PARTICIPATION

Studies of participation in continuing education activities indicate that the members of the several professions are not deeply committed to learning to maintain their professional knowledge and skill. Participation rates vary among the four professions and within each. The variation within a profession appears to be related to the degree of specialization of the members. On the whole, the rate of participation falls short of that considered essential by the leadership of the professions.

Individual participation in continuing education is a matter of the attitude and motivation of the individual as well as the relevancy of the programs available.

Attitudes

The formal school experiences of adults develop attitudes about learning that tended to become a barrier to participation in continuing education. The normal pattern of schooling is designed to terminate at various points commensurate with an individual's life goals and vocational expectations. As a result, individuals do not recognize or accept the idea that education must continue throughout life in order to maintain some reasonable adjustment with a rapidly changing world.

The health professions reinforce and in fact, accentuate this terminal concept of education by the ways in which the professions are structured. Admission to the profession is the terminal point in education for many members although those with higher expectations may set new terminal points in certain specializations or for specific positions in the profession. Thus, the attitude that education is terminal

is reinforced to the point where it mitigates against participation in education continuously.

The prevelance of this concept of education has plagued adult education as Kidd notes:

> This terminal concept has long stood in opposition to the more creative idea that education is inherently an 'open-ended' process which can never be definitely complete as long as life lasts; and that wherever on the ladder one's schooling may have 'terminated', there still remains an as yet unused capacity for mental and spiritual growth. The need and the capacity for education not only continues throughout life but actually increases as the individual matures, provided that the capacity to learn is persistently exercised.

Prior school experiences have also tended to develop rigid and restrictive attitudes about the nature and form of education and learning. From elementary school through university, education has been structured in set patterns of courses, classes, and subjects in which the learner has been involved only passively with emphasis in the acquisition of information. Consequently, activities are rejected if they fall outside the range of traditional school experiences, because individuals have not learned how to learn. Both those who plan programs for continuing education as well as potential participants are inhibited by these restrictive concepts about education.

Motivation

The motivation to participate is frequently governed by the achievement goals of an individual. The structure of the professions tends to restrict or reduce the motivation to participate so that only those motivated by personal satisfaction are apt to participate in further education after they have reached their terminal educational objective.

The growing interest in limited licensure in the health

professions is thought to be an incentive for increased participation in continuing education. This does little more than set recurrent terminal points that will undoubtedly motivate individuals to participate in programs. Thus, while it may increase attendance, limited licensure cannot automatically produce the learning that will lead to improved practice.

An individual may be motivated to attend a continuing education program because of limited licensure, but the motivation to engage in learning will develop only if the individual feels the need to learn and experiences the satisfaction resulting from successful learning. Thus, the participation in education essential to improved practice will occur only through good learning experiences.

Relevancy

Participation is influenced by an individual's perception of his need for learning so that he will be more apt to attend those activities that appear to be related to his needs and interests. The achievement of relevancy is, therefore, crucial but it is inhibited by the fact that few individuals are capable of identifying their need for learning accurately in functional terms.

In order to insure relevancy it is necessary to develop procedures for assessing the need for learning. The health professions have not yet discovered satisfactory ways of determining needs. Attempts to do so through self-assessment inventories succeed in helping to identify information deficiencies but this is not necessarily the real learning needs. Such inventories operate on the assumption that knowing leads automatically to doing but this is the most persistent fallacy in education. Thus, the identification of information deficiencies does

not necessarily apply to the real learning needs related to practice.

The several health professions have achieved little with respect to understanding and solving the problem of participation as attendance at an educational activity without sufficient attention to engagement in learning. Motivation to attend may be engendered in many ways but the corollary motivation to engage in learning will be achieved only through an awareness of the need for learning and successful efforts to satisfy that need.

Since the problem of participation in continuing education is so strongly influenced by attitudes toward education, the basic solution to the problem will require a major change in pre-professional education programs and in the structure of the professions to establish the concept of continuity in learning as a substitute for the present notion that education is terminal.

PROGRAMS

The principal objective of continuing education in the health professions is the achievement of the learning needed to improve patient care. The literature reviewed here presents scant evidence that this objective is actually reached. It also suggests that certain misconceptions about education may be at the root of the trouble. These popular prevailing misconceptions include the following:

1. The objective of education is the acquisition of information.
2. Information automatically results in practice.
3. Instruction is the process of diffusing information.
4. Learning is the same regardless of the age of the learner.

5. Learning is the same regardless of the material to be learned.
6. The same instructional processes are appropriate for all learning tasks and all learners.
7. Learning does not involve the active participation of the learner.

These and other similar myths about learning have inhibited the effective development of continuing education. Their interference is most noticeable with respect to the planning of educational programs and the management of instruction.

Planning

The four major health professions discussed here have shown some creativity in developing educational activities suited to their particular populations but these have been more the exception than the norm. Most of the programs reported in the literature have adhered to the traditional patterns characteristic of schooling and the specific objectives are rarely identified. Whether stated specifically or not, the objectives have been almost exclusively related to the acquisition of information. It is apparent that there is little awareness of the importance of identifying objectives as the first step in program planning. Consequently, most of the programs reported attempted to cover too much material in the time available, were not directed toward a clearly identified end, and could not be evaluated meaningfully. Only by establishing precise and uncomplicated objectives is it possible to plan useful programs, select content, choose appropriate instructional techniques, and measure the achievement of learning.

Instruction

Nearly all of the programs discussed in the literature used instructional processes that are effective primarily for the diffusion of information with the lecture being the most frequently used technique. None of the reports indicated any awareness of the desirability of selecting instructional techniques to fit the program objectives and the material to be learned. Furthermore, there was no indication that program instructors did more than act as instruments for the diffusion of information.

To accomplish learning effectively and efficiently it is necessary to manage learning which consists of a sequence of events which the learner must be guided through and provided knowledge of the results of his efforts. This guidance of learning is the responsibility of the instructor who must have knowledge of the conditions affecting learning and the ability to plan the sequence of events through which learning occurs. This management function appears to be one of the weakest aspects of continuing education in the health professions.

RESEARCH

Most of the published material about continuing education in the health professions is exhortative. None of the professions have produced any substantial body of research useful in developing this aspect of the profession. Medicine has produced the largest volume of literature and pharmacy the least.

Although each profession has certain unique characteristics that make it necessary to conduct specific research, there is much that is common to all of the health professions and to all adult education.

Because of this, interprofessional research into continuing education would be more economical as well as beneficial to all of the professions. There is little evidence in the literature to indicate that the professions know or have used relevant research about adult learning and instruction that has been produced outside the profession. Greater use of such existing research would enable each profession to concentrate on its own unique questions.

Most of the research literature is descriptive in that it reports programs and procedures used in providing opportunities for continuing education for a particular population. This is most useful for the general spread of innovative program ideas but it contributes little to the advancement of knowledge. Such reports can be enhanced by more complete information about objectives, instruction, the characteristics of the population, and similar data to permit an analysis of the program and the results achieved.

The survey method has been predominant in the studies reviewed. In most cases, this has suffered from inadequate sampling procedures and controls along with incomplete data processing. As a result, the findings are not necessarily valid or reliable, consequently the basic data needed to plan and conduct continuing education activities for the several professions is not yet available.

Very little analytical research that tests relevant hypotheses or seeks to answer crucial questions has been done. As this kind of research increases it will accelerate the accumulation of substantive knowledge about continuing education in the several health professions.

CODA

Although this review of the literature indicates that there is little room for complacency about continuing education in the several health professions, it does show clearly a rapidly growing interest in and concern for the quality and extent of educational opportunities. The design and conduct of educational activities for adults is itself a specialized body of knowledge and skill comparable to that in any of the health professions discussed here. It is unusual indeed to find individuals equally equipped for a health profession and for adult education. That this must eventually come to pass is inevitable. Thus, the initiation of improvements in continuing education for the health professions must begin with the development of personnel within each profession for whom adult education is an area of specialization equal to those now generally recognized and accepted by the professions.

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